Thursday, February 5, 2015

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MLN Connects™ National Provider Calls

Payment of Chronic Care Management Services under CY 2015 Medicare PFS — Register Now
Wednesday, February 18; 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

On January 1, 2015, CMS began making separate payment under the Medicare Physician Fee Schedule (PFS) for Chronic Care Management (CCM) services under Current Procedure Terminology (CPT) code 99490. CCM services are non-face-to-face care management/coordination services for certain Medicare beneficiaries having multiple (two or more) chronic conditions. During this MLN Connects™ National Provider Call, CMS will review the requirements for physicians and other practitioners to bill the new CPT code to the PFS. A question and answer session will follow the presentation.

Call participants are encouraged to review the following rules prior to the call: The 2014 PFS final rule (CMS-1600-FC) pages 74414-74427 and the 2015 PFS final rule (CMS-1612-FC) pages 67715-67730, which are available on the PFS web page.

Note: CPT codes, descriptions, and other data only are copyright 2014 American Medical Association. All rights reserved.

Agenda:
- Overview
- Eligible population
- Scope of service
- Question and answer session

Target Audience: Practitioners and providers interested in billing chronic care management services to Medicare, as well as coders, practice managers, and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

ICD-10 Implementation and Medicare Testing — Register Now
Thursday, February 26; 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

CMS is offering acknowledgement testing and end-to-end testing to help the Medicare Fee-For-Service (FFS) provider community get ready for the October 1, 2015 implementation date. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss opportunities for testing and results from previous testing weeks, along with implementation issues and resources for providers. A question and answer session will follow the presentations.

Participants are encouraged to review the testing resources on the Medicare FFS Provider Resources web page prior to the call, including MLN Matters® Articles and testing results.

Agenda:
- Participating in acknowledgement and end-to-end testing
- Results from previous acknowledgement and end-to-end testing weeks

- National implementation update
- Provider resources

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

New MLN Connects™ National Provider Call Audio Recordings and Transcripts

Audio recordings and transcripts are now available for the following calls:
- January 15 — *IRF PPS: New IRF-PAI Items Effective October 1, 2015:* audio recording and transcript. More information is available on the call detail web page. This call focused on training providers on how to code and complete the new arthritis attestation item and the therapy information section on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), along with clarification of the signature page requirements.
- January 21 — *ESRD QIP Payment Year 2017 and 2018 Final Rule*: audio recording and transcript. More information is available on the call detail web page. This call provided an overview of the final rule that operationalized the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) for Payment Year (PY) 2017 and PY 2018.

MLN Connects™ Videos

Monthly Spotlight: Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing

Want to learn more about the Individualized Quality Control Plan (IQCP) for Clinical Laboratory Improvement Amendments (CLIA) laboratory non-waived testing? Check out the following featured MLN Connects™ video slideshow presentation to learn more: Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing MLN Connects™ Call, 5/19/14.

During this short video slideshow presentation, CMS subject matter experts educate laboratories on the new quality control option for CLIA laboratories performing non-waived testing. IQCP will provide laboratories with flexibility in customizing Quality Control (QC) policies and procedures, based on the test systems in use and the unique aspects of each laboratory. IQCP is voluntary. Laboratories will continue to have the option of achieving compliance by following all CLIA QC regulations. The IQCP Education and Transition Period began January 1, 2014 and will conclude on December 31, 2015. This education and transition period gives laboratories the opportunity to learn about IQCP and implement their chosen QC policies and procedures. *Run time:* approximately 16 minutes.

Please Note: This video does not include the question and answer session that took place during the call. If you would like to listen to the audio or read the text of the question and answer session, go to the IQCP call detail page to access the audio recording and written transcript.

For More Information:
- For the latest CLIA information, including CLIA and IQCP Interpretive Guidelines, letters, and brochures, please visit the CLIA website.
- Submit questions to IQCP mailbox: IQCP@cms.hhs.gov.

- For additional MLN Connects resources, check out the [MLN Connects Calls and Events](#) web page where you will find slide presentations, audio recordings, and written transcripts from previous MLN Connects Calls, as well as a list of upcoming MLN Connects Calls.
- The MLN Connects National Provider Call Program has developed a variety of videos, many from previous national provider calls that can help you become more informed about the Medicare Program. For a list of other available MLN Connects videos, visit the [Medicare Learning Network® Playlist](#) on the [CMS YouTube Channel](#).

CMS Events

Special Open Door Forum: Home Health Clinical Templates
Wednesday, February 11; 1-2pm ET

To assist physicians in thoroughly documenting patient eligibility for the Medicare home health benefit, CMS is considering the development of a voluntary home health *paper* clinical template. A voluntary home health *electronic* clinical template has been in the development process for the past year. CMS believes the use of clinical templates may reduce burden on the physicians and practitioners who order home health services. To assist with the development of templates, CMS will host a series of Open Door Forum calls to obtain input from the public. The first call is Wednesday, February 11. More information is available on the [Home Health Electronic Clinical Template](#) web page.

Announcements

HHS Proposes Path to Improve Health Technology and Transform Care
ONC issues draft nationwide health IT Interoperability Roadmap; Implementation resources also released as first deliverable

On January 30, The HHS Office of the National Coordinator for Health Information Technology (ONC) released [Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0](#). The draft Roadmap is a proposal to deliver better care and result in healthier people through the safe and secure exchange and use of electronic health information.

Full text of this excerpted [HHS press release](#) (issued January 30).

Extension of Temporary Moratoria on Enrollment of New HHAs, HHA Sub-units and Part B Ambulance Suppliers

On January 29, 2015, CMS displayed a notice in the Federal Register ([CMS-6059-N2](#)) announcing that the temporary moratoria on the enrollment of new Home Health Agencies (HHAs), HHA Sub-units and Part B ambulance suppliers is being extended for an additional 6 months in certain geographic areas in Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey to prevent and combat fraud, waste, and abuse For more information see [MLN Matters Article #SE1425](#), "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers."

CLIA Individualized Quality Control Plan: Education and Transition Period Ends December 31, 2015

CMS is currently midway through the Clinical Laboratory Improvement Amendments (CLIA) Individualized Quality Control Plan (IQCP) Education and Transition Period. The IQCP is a new quality control option for laboratories performing nonwaived testing to meet the Quality Control (QC) requirements of CLIA. This plan uses a risk management quality management approach. The new option gives laboratories the opportunity to tailor a QC plan that is customized to their unique testing environment, while giving them the ability to adapt to new and future technologies. Laboratories should be using this time period to learn about IQCP and implement their chosen QC policies and procedures.

Currently, laboratories performing nonwaived testing have the option of following the CLIA QC regulations or using Equivalent Quality Control (EQC). Laboratories may continue to use these options during the Education and Transition period of January 1, 2014 through December 31, 2015.

Beginning January 1, 2016, laboratories performing nonwaived testing must use one of the following to be in compliance with CLIA:
- Follow the CLIA QC regulations; or
- IQCP

EQC will no longer be an acceptable QC option as of January 1, 2016. After the Education and Transition Period, any laboratory performing nonwaived testing using a QC plan less stringent than the CLIA QC regulations must perform an IQCP, or the laboratory will be cited for non-compliance. Regardless of the option chosen, the instructions and recommendations in the manufacturer's test package insert must continue to be followed.

More information regarding IQCP is available on the CLIA website, including new IQCP brochures for 2015. Questions may be sent to IQCP@cms.hhs.gov.

2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs

CMS has posted information for providers who rendered services at a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) in 2013 and are subject to the 2015 Physician Quality Reporting System (PQRS) payment adjustment:
- PQRS Listserv
- Frequently Asked Question

Open Payments: Second Year of Data Submission Begins

Beginning February 3, applicable manufacturers and applicable Group Purchasing Organizations (GPOs) can register or recertify their registration in the Open Payments system and begin data submission for any payments or transfers of value that occurred in the 2014 CY. All applicable manufacturers and GPOs must register or recertify their registration. Applicable manufacturers and GPOs can now submit corrected 2013 data (if needed) and submit their 2014 data to the Open Payments system. March 31, 2015, is the deadline for all submissions.

Physicians and teaching hospitals may also now register in the system, so they can be prepared to review any data that may be submitted about them. The review and dispute period for physicians and teaching hospitals is anticipated to start in April.

This is the second year of Open Payments data submission and supports ongoing efforts to increase transparency and accountability in health care. CMS plans to publish the 2014 payment data and make any applicable updates to the 2013 data in June 2015.For more information, please visit the Open Payments website.

If you have any questions, contact the Help Desk at openpayments@cms.hhs.gov or 855-326-8366, Monday through Friday, from 7:30am to 6:30pm CT, excluding Federal holidays.

CMS Intends to Engage in Rulemaking for EHR Incentive Program Changes for 2015

CMS intends to engage in rulemaking this spring to help ensure providers continue to meet meaningful use requirements. In response to input from health care providers and other stakeholders, CMS is considering the following changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs:

- Shortening the 2015 reporting period to 90 days to address provider concerns about their ability to fully deploy 2014 Edition software
- Realigning hospital reporting periods to the calendar year to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other quality programs
- Modifying other aspects of the programs to match long-term goals, reduce complexity, and lessen providers' reporting burden

These proposed changes reflect the HHS commitment to creating a health information technology infrastructure that elevates patient-centered care, improves health outcomes, and supports the providers who care for patients. While CMS intends to pursue these changes through rulemaking, they will not be included in the pending Stage 3 proposed rule. CMS intends to limit the scope of the pending proposed rule to Stage 3 and meaningful use in 2017 and beyond.

For more information:

- Read Dr. Conway's blog: CMS intends to modify requirements for Meaningful Use
- Visit the EHR Incentive Programs website

Get Started with Hospice CAHPS

February is the second month of the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Dry Run. If you are an eligible hospice, you must participate in at least one month of the Hospice CAHPS Dry Run (January, February, or March 2015), followed by ongoing monthly participation starting April 2015. To get started with Hospice CAHPS, you must contract with a CMS-approved vendor, authorize the vendor, and send them lists of patients for the sampled months. Successful participation in Hospice CAHPS can impact your Medicare Annual Payment Update for FY 2017. For more information, go to the Hospice CAHPS survey website, email technical assistance at hospicecahpssurvey@hcqis.org or call 844-472-4621.

Proposed Decision Memo: Screening for the HIV Infection

On January 29, CMS proposed to expand coverage in section 210.7 of the Medicare National Coverage Determinations Manual. CMS proposes that the evidence is adequate to conclude that screening for Human Immunodeficiency Virus (HIV) infection for all individuals between the ages of 15 and 65 years, as is recommended with a grade of A by the United States Preventive Services Task Force, is reasonable and necessary for the early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. See the Proposed Decision Memo (CAG-00409R) for additional information or to comment.

Claims, Pricers, and Codes

Home Health Pricer will be Updated on April 1

CMS has identified two errors in the 2015 home health Pricer that was put into production on January 1, 2015. A corrected home health Pricer will be installed on April 1, 2015. The corrections affect a small number of home health claims:

- Certain claims where the Pricer recodes the HIPPS code are being returned to the provider incorrectly, using FISS reason code 37224. Affected home health agencies may resubmit the returned claims after April 1.
- Claims for services provided in parts of rural Kansas (CBSA code 50045) are being paid but are not receiving rural add-on payments. Affected home health agencies should adjust their claims after April 1.

FY 2015 Inpatient PPS PC Pricer Update Available

The FY 2015.3 Inpatient Prospective Payment System (PPS) PC Pricer needed a logic correction and is now available with January 2015 Provider Data on the Inpatient PPS PC Pricer web page in the "Downloads" section.

Medicare Learning Network® Educational Products

"Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1504, "Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments" was released and is now available in downloadable format. This article is designed to provide education on a system change that will compare the Health Insurance Prospective Payment System (HIPPS) code on a Medicare home health claim to the HIPPS code generated by the corresponding Outcomes and Assessment Information Set (OASIS) assessment before the claim is paid. It includes information on how this change will be implemented and how it will impact home health agencies.

"Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article — Revised

MLN Matters® Special Edition Article #SE1425, "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" was revised and is now available in downloadable format. This article is designed to provide education on the extension of the temporary moratoria for an additional 6 months in certain geographic locations. It includes background information and tables. This article was revised to reflect an extension of the moratoria for an additional 6 months.

"Internet-based PECOS Contact Information" Fact Sheet — Reminder

The "Internet-based PECOS Contact Information" Fact Sheet (ICN 903766) is available in a downloadable format. This fact sheet is designed to provide contact information for technical assistance with Internet-based Provider Enrollment, Chain and Ownership System (PECOS). It includes a list of contacts and other resources.

Medicare Learning Network® Products Available In Electronic Publication Format

The following products are now available as an electronic publication (EPUB) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® Electronic Publication."

- The "Ambulance Fee Schedule" Fact Sheet (ICN 006835) is designed to provide education on the Ambulance Fee Schedule. It includes the following information: background, the Medicare ambulance transport benefit, ambulance providers and suppliers, Advance Beneficiary Notice of Noncoverage, payments, how payment rates are set, and updates to the Ambulance Fee Schedule.
- The "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet (ICN 006839) is designed to provide education on the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). It includes the following information: background, coverage requirements, how payment rates are set, fiscal year 2015 update to the IPF PPS, and IPF Quality Reporting Program.

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